Healthcare Disparities Report

Strategies t Funding t Programs t Policies

CD PUBLICATIONS
EST. 1961

WASHINGTON, OCTOBER 2006 NO. 06-10

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MEDICAID

Judge Denies Standing to Most Plaintiffs in Citizenship Documentation Case

A federal judge in Chicago denies standing to plaintiffs seeking to block enforcement of citizenship documentation by more than 40 million persons receiving or applying for Medicaid but grants standing to plaintiffs representing about 500,000 persons who have received foster care or adoption services under the Social Security Act. The judge refers the latter groups' request for a preliminary injunction to a magistrate judge.

The judge "misunderstands our pleadings," says John Bouman, director advocacy for the Sargent Shriver Poverty Law Center and the lead attorney on the case. He pledges to press ahead with the class action suit, *Bell v. Leavitt* (06C 3520). U.S. District Judge Ronald Guzman sets a status hearing for Oct. 5.

Meanwhile, Families USA, a Washington-based healthcare advocacy group, is conducting a state-by-state survey to determine the impact of documentation requirement.

The regulations "affect low-income people who unquestionably are legal citizens," asserts Ron Pollack, executive director of Families USA.

"This is the biggest change in eligibility for a federal program in my experience, and clearly it has created a whole new burden for the states," Elaine Ryan, deputy executive director for policy and government at the American Public Human Services Assn., tells *HDR*.

The Medicaid program long has required states to establish whether recipients/applicants are citizens or legal immigrants. The applicants could attest to their citizenship under penalty of perjury. Only Georgia, Montana, New Hampshire and New York required documentation.

But the Deficit Reduction Act of 2005 required applicants in all states to produce documentation of their citizenship status.

The Health & Human Services Dept. issued regulations to implement the change but exempted about eight million persons on Medicare or who are receiving Supplemental Security Income (*HDR*, 06/08p1).

Critics contend the documentation requirements are un-

necessary and could harm such vulnerable populations as the mentally disabled, disaster victims and nursing home residents

Info: The opinion is at www.povertylaw.org; Bouman, 312/263-3830, ext: 250; Pollack, 202/628-3030; Ryan, 202/682-0100

Advocates Have Wide Range of Ideas For Strengthening the Program

The Partnership for Medicaid urges the Medicaid Commission to adopt a wide range of proposals to strengthen the program. Medicaid provides healthcare to populations very likely to experience disparities.

The Partnership, a group of 15 professional associations and the AFL-CIO, makes proposals in five areas:

Quality−Greater use should be made of health disparities collaboratives, Provider Service Networks, Medicaid managed care, care-management initiatives and improved disease management.

Quality Measurement−The federal government should provide financial support for the application of quality-measurement techniques to the Medicaid population that have worked for other groups, including those who rely on employer-based health insurance and Medicare recipients.

Disease Prevention & Health Promotion−Efforts should be made to ensure Medicaid recipients have a regular source of healthcare, which research has shown leads to improved use of appropriate services and reduces inappropriate use of hospital emergency rooms. In addition, emphasis should be placed on early detection, patient education and health literacy. Solutions would include formation of community health networks, Medicaid reimbursement for programs to educate clinicians on proper communications techniques with low-literacy patients, and wider use of the Early & Periodic Screening, Diagnosis & Treatment program.

Long-Term Care−Expand the Program of All-Inclusive Care for the Elderly (PACE), encourage and support greater use of long-term care insurance, and leverage home equity to pay for care where appropriate and with protections for the patients.

Pharmaceutical Costs−The Partnership recommends **t**ighten administration of the program under which states receive a rebate from drug manufacturers based on utilization and increase the rebate level from the current 23%. In addition, the dispensing fee paid by states to pharmacists should reflect the true costs of drugs and services. Medicaid managed-care programs should have access to the drug rebate.

Info: www.nachc.com, click on Hawkins' statement under Recent News.

QUALITY

Commonwealth Fund 'Scorecard' Ranks U.S. Behind Other Nations in Healthcare

The United States lags behind other nations in the quality of healthcare the Commonwealth Fund Commission on a High Performance Health System reports in its first annual Nat'l Scorecard.

If the United States improved performance in key areas, the nation could save an estimated 100,000-250,000 lives and $50 billion-$100 billion each year, the report says.

Increasing healthcare quality widely is believed by experts to be linked intrinsically to decreasing disparities.

The report, *Why Not the Best?*, says that the United States scores an average of 66 out of a possible 100 across 37 national indicators of health outcomes, quality, access, equity and efficiency.

The system is hard on minorities, the report finds:

- Overall, it would require a 24% or greater improvement in mortality, quality, access and efficiency for blacks to approach white levels.
- On average, it would require a 20% decrease in Hispanic risk rates to reach white rates.

Healthcare Disparities Report (ISSN 1548-8268) is an independent news service published monthly. Copyright 2006 by CD Publications, est. 1961, 8204 Fenton St., Silver Spring, MD 20910. Fax: 301-588-6385. Web site: www.cdpublications.com. **Editorial or Subscription inquiries:** 301-588-6380 (9 a.m.-5:30 p.m. Eastern Time) or e-mail info@cdpublications.com. **Editor**: James S. Byrne; **Managing Editor:** Joe Haas; **Publisher:** Ellen Gerecht. **Subscription rates:** $299/year print or online. $337 for print and online. Back issues: $20 prepaid. Multi-year/multiple copy/site license discounts available. GSA Schedule #GS-02F-0047R. Subscriptions are allowable expenses under certain federal grants.

The country ranks at the bottom among industrialized countries on health life expectancy at birth or age 60 and last in infant mortality.

The United States falls short on universal health insurance coverage and on measures of preventive and primary care. This hurts health outcomes and raises the cost of care, the report says. Universal coverage and participation is the top one of seven "central messages" from the Scorecard, the study says.

Others include finding improvements that enhance both quality and efficiency, linking providers and information to better coordinate care, devising payment incentives to reward better care, improving data systems including the use of electronic medical records, generating savings from more efficient use of expensive resources including more effective care to control chronic disease and assure patients of timely access to primary care, and setting national goals for improvements based on best achieved rates.

The 18-member commission was formed in April 2005 and is chaired by Dr. Walter Mongan, CEO of Boston-based Partners HealthCare.

Info: www.cmwf.org

CMS to Fund 'Gainsaving' Demo That Could Reduce Disparities

The Centers for Medicaid & Medicare Services are seeking applicants to participate in a major demonstration program that could have an important impact on disparities populations.

The project, established by the Medicare Modernization Act of 2003, will test the effectiveness of gainsharing, an arrangement under which hospitals and physicians share in the financial savings from improved quality and efficiency. The demonstration will feature long-term followup of patients whereas previous demonstrations focused solely on the inpatient stay.

"This could be very germane to disparities populations," Dr. Bruce Siegel tells *HDR*. "For many minority patients the great challenge is continuity after they leave the hospital, ensuring they get the follow-up care and appropriate medications they need," he explains.

Siegel, a research professor at the George Washington U. Medical Center School of Public Health & Health Services, is directing a collaborative project among 10 hospitals to reduce/eliminate disparities in the treatment of heart disease (*HDR*, 05/11p5).

"The gainsaving approach may be very exciting for something like congestive heart failure," he adds. "Even a small decrease in hospitalizations could save CMS real money and those savings could be used for financial incentives for physicians."

The MMA authorizes up to six demonstration projects. Applications are due Jan. 9, 2007. The projects will be operated in various geographical areas and will include a maximum of 72 hospitals.

The goals of the demonstration are to:

- Improve patient safety.
- Enhance quality of care by increasing efficiency.
- Reduce scientific uncertainty and unwarranted variation in medical practice that produce lower quality and increased costs.

Info: *Federal Register*, 9/11p53455; siegelmd@gwu.org

RESEARCH & REPORTS

Poverty Level Unchanged in '05 But Still a Public-Health Concern

This story was sent via e-mail to subscribers Aug. 31.

The nation's poverty rate remained unchanged in 2005 at 12.6%, but it still was higher than the 11.7% recorded in 2001 when the recession bottomed out and the recovery began, Census Bureau figures released Aug. 29 show. Those results, plus an increase in the number and share of the uninsured (see story p?), have serious negative implications for public health.

Also unchanged was the proportion of the population living in severe poverty—half or below the official poverty level. The share remained at 5.4%, equal to 15.9 million people, marking the first time since 2000 there has not been an increase.

"It's good news it didn't go up, but it still is evidence there is a potential healthcare crisis for the most vulnerable," Dr. Steven Woolf, professor of family medicine, epidemiology and community health at Virginia Commonwealth U., tells *CHF*.

Woolf says the percentage of the population living at or below half the poverty level rose 20% from 2000-04. The federal poverty level in 2005 for a family of four was $19,971.

Children and minorities comprise a substantial share of those living below half the poverty level, he says. About one-third of those living in severe poverty are children; 45% of blacks and 44% of Hispanics experiencing severe poverty are children, he adds.

"The public-health implications of increasing poverty are profound, given how strongly social class is linked with premature death, disease and mental illness," he warns.

Woolf's findings are detailed in the October issue of the *American Journal of Preventive Medicine*.

In 2005, the poor became poorer, asserts the Center for Budget & Policy Priorities. The average amount ($3,236) by which anyone who was poor fell below the poverty line−the poverty gap−was the highest ever as was the percentage (43.1%) of the poor living at or below half the poverty level.

Poverty rates in 2005 ranged from a low of 7.5% in New Hampshire to a high of 21.3% in Mississippi,

Despite the impact of the 2001 recession, the 9/11 terrorist attacks and the devastation of the Gulf hurricanes, there were 90,000 fewer people living in poverty in 2005 than the year before and real average income rose for families in every income quintile, the Office of Management & Budget said in a statement.

Info: The Census Bureau report, *Income, Poverty & Health Insurance Coverage in the United States: 2005*, is at *www.census.gov*, go to Newsroom; the CBPP analysis is at www.cbpp.org; Woolf, 804/828/9625; swoolf@vcu.edu

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Study Finds Life Expectancy Disparities Will Not Be Solved by Healthcare Access

A new study finding striking disparities in life expectancy across the United States offers still more evidence that simply ensuring access to healthcare will not solve the problem.

The disparities in life expectancy "cannot be explained by race, income or basic healthcare access and utilization," the study concludes. But "because policies aimed at reducing fundamental socioeconomic inequalities are currently practically absent in the U.S., health disparities will have to be at least partly addressed through public health strategies that reduce risk factors for chronic diseases and injuries," the researchers say.

Dr. Paula Braveman, director of the Center on Social Disparities in Health at the U. of California−San Francisco, agrees. "We must also find ways to close the disparities in the conditions in which people live and work--the profoundly different opportunities to be healthy that go along with, for example, where a baby is born into a family that is rich or poor, white or black−that are the fundamental causes of disparities in health," she tells *HDR*.

The same views are expressed by Dr. H. Jack Geiger, professor emeritus at City U. of New York, who notes he gives a lecture and slide show making the case that the federal government's Healthy People 2010 will fail in its promise to eliminate disparities because it focuses almost exclusively on access to healthcare and changes in personal behaviors. Many studies, including those done in countries with universal healthcare, find that access and changes in personal behaviors "account for less than 45% of disparities between the poor and minorities and the more affluent," he tells *HDR*.

The study recommends:

- Systematic epidemiological and economic analyses to identify cost-effective health interventions.
- Development of monitoring systems by states and territories to provide local, benchmarked information on the fraction of the population in each community who can benefit from the interventions and whether they are receiving the care.
- Public reporting of the results to increase accountability for health outcomes.

The study was led by Dr. Christopher Murray, director of the Harvard U. Initiative for Global Health, and divided the country into "Eight Americas," based on race, location of county of residence, population density, race-specific county level per capita income, and cumulative homicide data.

It found the difference in life expectancy between the most and least healthy groups was 33 years. Asian American women in Bergen County, NJ, had the highest life expectancy of 91 years and Native American men in several South Dakota counties had the lowest at 58 years.

Info: The study is at http://medicine.plosjournals.org; Braveman@fcm.ucsf.edu; jgeiger@igc.org; christopher_murray@harvard.edu

UNINSURED

Uninsured Reach Record Level but Some Are Hopeful State Initiatives Can Help

This story was sent via e-mail to subscribers Aug. 31.

The number of uninsured increased to a record 46.6 million, or 15.9% of the population, in 2005 from 45.3 million, or 15.65, the year before, the Census Bureau reports, and the situation could get even worse, warns Robert Greenstein, executive director of the Center on Budget & Policy Priorities.

He notes the reversal in the proportion of uninsured chil-

dren, which rose to 11.2% in 2005 after dropping to 10.8% in 2004 from a high of 15.4% in 1998, may continue.

In FY 2007, 17 states face federal funding shortfalls totaling $800 million in State Children's Health Insurance Programs (SCHIP), he says. This is equal to the cost of covering more than 500,000 low-income children.

The Bush administration's FY 2007 budget proposes spending to cover the shortfall but Congress has not acted on it.

The principal reason for the increase in the uninsured is the continued decline in the proportion of persons covered by employment-based health insurance, which dropped to 59.5% from 59.8%, the Census report shows.

The report shows the lack of insurance is more common among people with low incomes. About 24.4% of persons with incomes below $25,000 were uninsured compared with 8.5% of those with incomes of more than $75,000.

Hispanics (32.7%) and blacks (19.6%) were more likely than non-Hispanic whites (11.3%) to be uninsured.

"These findings point to the need for a national solution to ensure that all Americans have affordable and comprehensive health insurance coverage and access to needed healthcare," says Karen Davis, president of the Commonwealth Fund.

In the absence of federal government action to produce that result, Davis says, several states, including Massachusetts and Maine, have come up with innovative solutions.

Rachel De Golia, operations director of Cleveland-based Universal Health Care Action Network, sees the state initiatives as evidence that at least some politicians have the political will to do something about the growing number and proportion of the uninsured.

In addition, she is hopeful the introduction of bipartisan bills (S 2772, HR 5864) in Congress to support state efforts will at last produce federal action to deal with the problem of the uninsured.

Marilyn Clement, national coordinator for HealthcareNOW, a group campaigning for single-payer universal healthcare, notes the largest number of newly uninsured are in families with income of $50,000-$60,000, including the children cited by Greenstein. This impact on the middle class should bring political pressure for change, she adds.

Info: Census report is at www.census.gov, go to Newsroom; CBPP analysis is at www.cbpp.org; de Golia, 800/634-4442, ext 14; degolia@uhcan.org; Clement, 212/475-8350; marilyncle@earthlink.net

OUTREACH

Assn. of Clinicians for the Underserved Believes Key Is Transdisciplinary Care

The priority for the Assn. of Clinicians for the Underserved as it marks 10 years of service with its first national conference is transdisciplinary care. This is a collaborative approach to consumer-centered care that involves caregivers and those seeking their services as well as a broad range of partners, including corporations, advocacy organizations and foundations working together to improve health outcomes, explains Kathie Westpheling, executive director of the Tysons Corner, VA-based organization.

ACU's core program areas, she tells *HDR*, comprise:

- Improving communications between the underserved and the health professionals and organizations committed to serving them, increasing the health literacy of all and improving the quality of care.
- Supporting caregivers with relevant resources and promoting a wellness agenda for the health workforce.
- Promoting health equity and access for all.

The Sept. 29-Oct. 1 Washington conference will feature a community meeting with discussants representing medical caregivers, the public health sector, consumers and students preparing for careers in healthcare.

ACU was established in 1996 by alumni of the Nat'l Health Service Corps, which offers financial support to students and certain primary caregivers who then serve in areas with a shortage of providers. But it has expanded well beyond NHSC alumni to include a constituency of more than 8,000 clinicians and 900 organizations. Membership includes persons in 18 professional disciplines, community clinics, healthcare organizations and professional societies.

"We are all about caring for the caregiver, especially frontline clinicians who want to be successful in the work they do with the underserved," says Westpheling, a public health nutritionist who joined ACU just after it was founded and became executive director in 2002.

She cites as major successes ACU's partnership the *Journal of Health Care for the Poor & Underserved* and the many successful partnerships among persons and institutions committed to serving that population.

But the key to success is the transdisciplinary model, insists, Westpheling. One example of this model in action notes Lois Wessel, ACU's associate program director, a

family nurse practitioner and NHSC alumna, is a required ethics course at her alma mater, Georgetown U.

The students range from nurses who have had to make life-and-death decisions in hospitals and clinics to medical students who have yet to meet a patient. "It is a unique opportunity for students with different caregiving experiences to learn valuable lessons from each other, their patients and their patients' families," she adds.

Info: Westpheling, 703/442-5318; kathiew@clinicians.org; Wessel, lwessel@igc.org

ADVOCACY

Working Group Recommendations May Shape Healthcare Coverage Debate

The final recommendations of the Citizens' Health Care Working Group, which will closely track an interim version issued in June, will be less important for their substance than for how they will shape future debate over how to increase coverage, say leaders of two groups with opposite views on the issue.

The final report of the Working Group is scheduled to be issued in the last week of September.

Representatives of Physicians for a Nat'l Health Plan, who attended several of the public forums held by the Working Group, assert that despite being presented with questions they believe were designed to elicit support for options other than national health insurance program, participants clearly favored a national plan over alternatives.

Grace-Marie Turner, president of the Galen Institute, which favors so-called consumer-directed healthcare that relies on market incentives like healthcare savings accounts to increase coverage, agrees the comments of forum participants will be used as an argument for increased federal government involvement in providing healthcare coverage. But she is not pleased at that prospect.

"The majority of those who showed up at those forums had a vested interest in a government-supported health system," she tells *HDR.*

If the November elections give the Democrats control of one or both houses of Congress, the views expressed at the forums are likely to be used as evidence of strong public support for government-financed solution to increased coverage, she adds.

She says the Working Group did not take on difficult questions such as how to finance any of its recommendations.

"I will be watching very carefully how the White House characterizes the recommendations," she adds.

President Bush will have 45 days after he receives the report to send his views to Congress.

The panel's recommendations include a commitment to a policy that all Americans have affordable health and that they be guaranteed financial protection against very high healthcare costs (*HDR*, 06/07p3).

Info: The interim recommdations are at www.citizenshealthcare.gov; www.pnhp.org; Turner, 703/299-8900; www.galen.org

PROVIDERS

Hospitals: Finance Chair Grassley Wants Proposals to Ensure Care for Poor

Senate Finance Chairman Chuck Grassley (R-IA) directs committee staff to develop proposals on ways to make sure nonprofit hospitals deliver care to the poor and provide benefits in their communities to justify their tax-exempt status.

The action comes after a Sept. 13 hearing at which Sr. Carol Keehan, president of the Catholic Health Assn., reports 95% of CHA member health systems and 90% of individual hospitals have passed resolutions committing themselves to using CHA's *A Guide for Planning & Reporting Community Benefit*. In addition, they signed pledges to put notices in key areas of hospitals about the availability of charity care for low-income persons.

Kevin Lofton, chairman-elect of the American Hospital Assn., tells the panel the AHA board in May passed a resolution calling for standardized public reporting of community benefit, using the CHA model.

The resolution also calls upon members to provide free care to persons below 100% of the federal poverty level and financial assistance to those between 100%-200% of the FPL. And the board urged members to better monitor their collection practices.

But the day before the Sept. 13 hearing, distributes a memo reporting a 15-month investigation of nonprofit hospitals by committee staff found instances of overcharging and denying service to uninsured and underinsured persons, as well as failing to inform low-income patients of their eligibility for free care or financial assistance.

Grassley, praises CHA for providing leadership in developing the guidelines for public accounting of community benefits. But he says the 15-month investigation, in

cluding questionnaires to 10 major nonprofit hospitals, found nonprofit hospitals have no consistent method of reporting.

He expresses hope "not to have to enact legislation on the issue," but says there is a need for more transparency. He urges all nonprofits to adopt the CHA reporting standards.

The Finance and House Ways & Means Committees have been investigating a broad range of tax-exempt organizations, including hospitals, for some time.

The Internal Revenue Service recently sent out a nine-page questionnaire to 550 nonprofit hospitals to determine whether they are violating standards for their tax-exempt status (*HDR*, 06/08p4).

Info: The Keehan and Lofton prepared testimony is at http://finance.senate.gov, click on Hearings; for Grassley memo, click on Press Releases; Keehan, 202/296-3993; Lofton, 202/638-1100

ON CAPITOL HILL

Christensen Says Senate Disparities Bill Doesn't Measure Up to Dems' Proposal

A bipartisan Senate healthcare disparities bill is still being written, but Del. Donna Christensen (D-Virgin Islands), who has seen a draft of the measure, says it "is far too modest and does not represent a compromise."

Christensen, who chairs the Congressional Black Caucus (CBC) Health Braintrust, receives strong support for her position from participants in a forum during the Annual Legislative Conference of the CBC Foundation.

The draft has not been made public but Christensen tells the audience the measure is inferior to the proposed Healthcare Equality & Accountability bill (HR 3561, S 1580) introduced last year with no Republican support.

The draft "contains all of the right buzz words and includes objective we all support [but] the provisions … will not accomplish what they purport to do," says Christensen in a written critique. "Consequently, it will lower the bar on health disparity elimination."

The draft "is inconsistent with and incongruent to the recommendations for and the definitions of health disparity elimination" that the Health & Human Services Dept., the Institute of Medicine and others have released in recent years, she says.

"If this bill moves, we are not likely to see the issue of health disparity elimination prioritized again for several congressional sessions.

Staff participants in the drafting exercise have declined to provide copies or comment publicly while the work is in progress. The Senate effort to produce a bipartisan disparities bill is led by Majority Leader Bill Frist (R-TN).

HR 3561/S 1580, among other things, would expand existing public insurance programs, such as the State Children's Health Insurance Programs, and establish new initiatives to reduce disparities and expand current efforts.

Info: Christensen, 202/225-1790; HR 3561 and S 1580 are at www.loc.gov/thomas

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Senate Approval Expected for IHCIA

The Senate is expected to pass a compromise version of a bill (S 1057, S Rept 109-222) to reauthorize the Indian Health Care Improvement Act (PL 94-437), something Congress hasn't done since 1992. The law has been implemented under the broad authority of the Indian Health Service, supported by regular appropriations (*HDR*, 06/09p3).

Kitty Marx, legislative director for the Nat'l Indian Health Board, tells *HDR* the Coalition for the Reauthorization of the IHCIA is working to persuade the House Energy & Commerce Committee to approve the measure at a scheduled Sept. 27 markup.

The Senate compromise melds S 1057 with a bill (S 3524, S Rept 109-278) passed by the Senate Finance Committee to make changes to Medicaid the State Children's Insurance Program as they affect Indian health services.

Info: Marx, 202/742-4328; bills are at www.loc.gov/thomas

Senate Votes for Indian Child Protection

The Senate approves a bill (S 1899, S Rept 109-255) reauthorizing the Indian Child Protection & Family Violence Prevention Act through FY 2011.

The measure makes several changes to strengthen enforcement under the law, including requiring the Secretary of the Interior to collect annually information about criminal and civil child abuse allegations and prosecutions, the number of victims report in Indian country and sentencing patterns for persons convicted of child abuse.

Info: S 1899 is at www.loc.gov/thomas

DISEASE MANAGEMENT

Obesity: Prevention Advocacy Group Faults Government Policy Efforts

Government policy efforts have failed consistently to provide viable solutions to the growing obesity crisis charges the Trust for America's Health (TFAH) as it reports obesity rose in 31 states in 2005. No state is on track to meet the national goal of reducing obesity levels to 15% or less by 2010, TFAH predicts.

TFAH, a nonpartisan organization that focuses on disease prevention, proposes a 20-step action plan.

The national average of persons overweight or obese rose to 32% in 2004 from 15% in 1980, TFAH says. Childhood obesity more than tripled during the period to 17% from 5%.

The report, *F as in Fat*, is the third in a series of what will be annual reviews of the obesity problem. Most numbers reflect an average of three years so the current report is based on data for 2003-05.

Mississippi at 29.5% had the highest average for the three years while Colorado with an adult obesity rate of 16.9% was the lowest.

Among TFAH's recommendations are:

- Initiate fast-track research to identify evidence-based interventions and best practices.
- Break the cycle of short-term government action by developing and implementing a series of viable long-term, fully funded solutions. TFAH says federal spending on chromic disease prevention is about $3 per person annually, less than most fast food meals.
- Develop an appropriate set of indicators to measure progress. Instead of emphasizing weight loss, measure improved nutrition and physical activity.
- Support community-driven efforts that increase access to health foods for low-income persons and improve the environment with sidewalks, parks and bike paths to encourage exercise.
- Improve nutrition in schools and strengthen the physical fitness criteria.
- Increase employer-sponsored programs such as subsidized health club memberships.
- Support food. Beverage and marketing industry initiatives that improve nutritional practices.

Info: http://healthyamericans.org, click on Reports, then on TFHA Reports

SPECIAL POPULATIONS

Children: HRSA Finds 14.8% of Kids Are Overweight; 23.5% for Blacks

The Health Resources & Services Admin. (HRSA) reports 14.8% of 10-17-year-olds are overweight but black and Hispanic children exceed that average. Overweight in children is a principal predictor of obesity among adults.

Black children have the highest rate (23.5%), followed by Hispanics (18.9%) and whites (12%).

Males (18.1%) are more likely than females (11.5%) to be overweight.

As family income rises, the proportion of overweight children declines. Children in families below 100% of the federal poverty level (FPL) had a 22.4% rate compared with 9.1% for children in families with income of more than 400% of FPL.

HRSA reports 71.3% of children exercise at least three days a week but that number also increases with family income. Children in families with income below 100% of FPL had a 65.6% exercise rate while those in homes above 400% of FPL report a 75% rate.

It is the third HRSA analysis based on data collected in 2003-04 by the Nat'l Survey of Children's Health, a telephone survey of parents or guardians in more than 100,000 households with children under 18.

Info: www.hrsa.gov

FUNDING OPPORTUNITIES

Federal Grants

CHC Applications Due Nov. 13, Dec. 15

Agency: *Health Resources & Services Admin., Bureau of Primary Health Care.* ***Program:*** *Consolidated Health Centers.* ***Eligibility:*** *Public nonprofit private entities, including tribal community- and faith-based organizations; organizations proposing to serve the same service area served by currently funded health center; currently funded health centers; consortia of health centers whose partnership can serve the entire service area.* ***Funding:*** *28 awards for areas served through grants ending April 1-May 1, 2007, and 34 awards for areas served by grants ending June 1-July 1, 2007.* ***Deadlines:*** *Nov. 13 for first category, Dec. 15 for second.*

Summary: Federally qualified community health centers

provide healthcare to underserved communities.

Info: Martha Teague, 301/594-6096; Martha.Teague@hrsa.hhs.gov; http://apply.grants.gov/agency GetGrantFromFedgrants?cfda=&opportunity=HRSA-07-008&competitionid=

NIH Aids Minority Research Careers

Agency: *Nat'l Institutes of Health.* ***Program:*** *Clinical Research Education & Career Development(CRECD) in Minority Institutions.* ***Eligibility:*** *Public or private institutions of higher learning serving racial/ethnic minorities. Foreign institutions are not eligible. Individuals must have the skills, knowledge and resources to carry out the proposed research as project director/principal investigator.* ***Funding:*** *$2 million for 3-5 new awards and renewals.* ***Deadline:*** *Nov. 30.*

Summary: CRECD awards are intended to support development and implementation of curriculum-dependent programs in minority institutions to train selected doctoral and postdoctoral candidates in clinical research leading to a master of science degree in clinical research or a master of public health degree in a clinically relevant area.

Info: http://grants.nih.gov/grants/guide/rfa-files/RFA-RR-06-003.html

NIH Offers Educational Repayments

Agency: *NIH.* ***Program:*** *Health Disparities Research Loan Repayment Program.* ***Eligibility:*** *U.S. citizens or permanent residents with an MD, PhD, Pharm. D, D.O., D.D.S, D.M.D, D.P.M., Psy. D., D.C., D.V.M, N.D. or equivalent doctoral degree from an accredited institution. Applicant must conduct health disparities research for 240 hours (based on a 12-week quarter) or 260 hours (based on a 13-week quarter. The research must be funded by the federal, state or local government agencies or by a domestic nonprofit.* ***Funding:*** *In exchange for a two-year commitment to disparities research, NIH will repay up to $35,000 per year of qualified educational debt. Deadline: Dec. 1.*

Summary: The goal is to provide an incentive for health professionals to engage in basic, clinical or behavioral research directly relevant to health disparities. Half the awards will be made to individuals from disparities populations.

Info: Dr. Francisco Sy, 301/496-7074; syf@mail.nih.gov; www.lrp.nih.gov/about/Lrp-healthdisp.htm

NIH Funds Disparities Research

Agency: *NIH.* ***Program:*** *Disparities Research.* ***Eligibility:*** *Federal agencies; state, county local and tribal governments; independent school districts; for-profit entities; institutions of higher education; public/Indian housing authorities.* ***Funding:*** *Total amount not specified. Award ceiling is $200,000.* ***Deadline:*** *Multiple, see announcement on HDR Web site (below).*

Summary: Purpose of grants is to stimulate research aimed at reducing healthcare disparities among minority and underserved women. Specifically, the initiative seeks applications for research focusing on health promotion and risk reduction and intervention studies that show promise for improving health.

Info: http://grants.nih.gov/grants/guide/pa-files/PA-04-153.html

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Private Grants

Minority Health Fellowships Available

Jan. 2 is the application deadline for the Commonwealth Fund/Harvard U. fellowships in minority health. The one-year fellowship for physicians leads to a master's in public health at the Harvard School of Public Health or a master's in public administration at the John F. Kennedy School of Government.

Applicants must be U.S. citizens, board eligible or certified with experience in minority health issues.

The fellowship includes a $50,000 stipend, tuition and fees, health insurance and other program expenses.

The fellowships are funded by CMWF and administered by Harvard.

Info: Dr. Joan Reede, director, 617/432-2922; mfdp_cfhuf@hms.harvard.edu

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APFA Has Awards for Aiding Minorities

The deadline is Nov. 1 for the American Psychiatric Foundation Awards for Advancing Minority Mental Health, formerly known as the Minority Mental Health Awards. The prizes recognize psychiatrists and other health professionals, as well as mental health programs and other organizations that have made innovative ef-

forts to raise awareness of mental illness and improve access to treatments in minority communities.

Four awards of $5,000 each will be awarded to licensed health professionals and mental health programs and other organizations that have been in operation for at least two years.

Info: APF, 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209, phone: 703/907-8512; apf@psych.org; www.psychfoundation.org, click under first item under Dates to Know at lower right.

Magic Johnson Funds AIDS Projects

The Magic Johnson Foundation is accepting applications for its HIV/AIDS Grants program, which helps organizations in inner cities provide outreach, education, prevention, health and social services related to HIV/AIDS.

Eligible applicants include nonprofit organizations providing programs in California, Atlanta, Cleveland, Chicago, Houston, New York City and Washington DC. Grants range from $5,000-$25,000.

Info: 9100 Wilshire Blvd. Suite 700 East, Beverly Hills, CA 90212; phone, 310/246-4400; Web, www.magicjohnson.org/grants.php

Tiger Woods Focuses on Underserved

The deadline is Nov. 1 for applications to the Tiger Woods Foundation, which focuses its grantmaking on underserved children and families, with health and welfare among the foundation's top priorities.

This is a good candidate for seed money, but not long-term support. The foundation makes one-year grants to nonprofit programs based primarily in urban areas.

Applicants must have other sources of support. The TWF grant may not be any more than 25% of the organization's budget, and applicants must have received at least $100,000 from other sources.

Info: Tiger Woods Foundation, 714/816-1806; grants@twfoundorg; www.twfound.org

MultiPlan Has Rural Hospital Grants

The deadline is Oct. 16 for applications for MultiPlan's 2006 Rural Health Outreach Program, which helps clinics in rural areas expand services and increase access to care. Grants of $3,000 will go to 10 hospitals serving rural communities nationwide. Recipients in 2005 included Carolina Pines Regional Medical Center in Harstville, SC, for a heart disease outreach program, and Evergreen Medical Center in Evergreen, AL for a wellness program for at-risk children and their families.

Applicants must be a hospital in a non-metropolitan area and be a current member of the MultiPlan Network. MultiPlan is an independent healthcare network serves insurers, healthcare payers and care providers.

Info: Rural Health Outreach Program, Attn: Kathleen Thomas, MultiPlan Inc., 6608 Raytown Rd., Suite 206, Kansas City, MO 64133, rural@multiplan.com; www.multiplan.com/pdf/2006%20Rural%20Grant%20Application.pdf

Gulf Healthcare Groups Can Get Aid

Healthcare organizations in areas affected by the Gulf Coast hurricane last year can obtain funding from the Johnson & Johnson 2007 Community Health Care Program.

The effort, which includes partnerships with the Johns Hopkins Bloomberg School of Public Health and the Nat'l Council of La Raza, provides funding for programs for the medically underserved, especially those focusing on women and children. A total of six grantees will receive a two-year grant of $150,000 each ($75,000 per year).

Funding during the 2007-2009 Community Health Care grant cycle will be made available to organizations in Alabama (all areas), Louisiana (Baton Rouge & New Orleans only), Mississippi (all areas) and Texas (Houston only).

Info: J&JCHCP, www.jhsph.edu/johnsonandjohnson

RWJF Sets NJ Initiative for Vulnerable

The Robert Wood Johnson Foundation launches a $2.4 million grant program in New Jersey to support community-based projects focusing on vulnerable populations, childhood obesity and addiction prevention and treatment. The application deadline is Oct. 17.

Applicants can be healthcare providers, long-term care providers, physician and other provider organizations, statewide or regional organizations related to providers, organizations that target an underserved group, planning organizations and advocacy groups.

Grants will range from $50,000-$300,000.

Info: www.rwjf.org.